

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

COUNTY

Calvert

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

X TOWN Prince Frederick

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

64 Calvert County Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville 16152

STREET ADDRESS

(If rural give location)

## 3. NAME OF DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

## 5. SEX:

Male White

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

## 8. DATE OF BIRTH:

July 20, 1955

## 4. DATE (Month) (Day) (Year) OF DEATH:

July 21, 1955

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME:

Carl Donald Bell

## 14. MOTHER'S MAIDEN NAME:

Mary Virginia Hasenmiller

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Mary Bell - Hyattsville, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X

## IMMEDIATE CAUSE

## (A) DUE TO

Premature

## ANTECEDENT CAUSE (S):

## (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

## (C) DUE TO

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/20, 1955, to 7/21, 1955, that I last saw the deceased alive on 7/21, 1955, and that death occurred at 2 P M, from the causes and on the date stated above.

SIGNATURE

J. H. Hensley

ADDRESS

M. D. Huntingtown

DATE SIGNED

7/21/55

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

7/22/55

Grace L. Hutchins

M. D. Hutchins

7/22/55

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1955

BUREAU V. S.

6459

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH:  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |   |  |
| COUNTY <i>Calvert</i>   |  | MARYLAND   |  | STATE <i>Md.</i>   |  | COUNTY <i>Calvert</i>   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)          |  |   |  |
| X TOWN <i>Pr. Frederick, Md.</i>  |  | 3 months   |  | OR TOWN <i>Prince Frederick</i> X  |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co. Hosp.</i>  |  |  |  | STREET ADDRESS (If rural give location)  |  |   |  |
| 3. NAME OF DECEASED: (Type or Print)  |  |  |  | 4. DATE (Month) (Day) (Year)   |  |   |  |
| (First) (Middle) (Last)   |  |  |  | OF DEATH: <i>July 6, 1957</i>  |  |   |  |
| 5. SEX: <i>Female</i>   |  | 6. COLOR OR RACE: <i>Colored</i>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>               |  | 8. DATE OF BIRTH: <i>May 7, 1896</i>                              |  |
| 9. AGE last birthday: <i>65</i> yrs.  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  | Months Days Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House work</i>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY:   |  | 11. BIRTHPLACE (State or foreign country): <i>Calvert co. Md.</i> |  |
| 13. FATHER'S NAME: <i>Ham Hardman</i>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>                                       |  |   |  |
| 14. MOTHER'S MAIDEN NAME: <i>Unknown</i>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>Unknown</i> |  |   |  |
| 16. SOCIAL SECURITY No. <i>220-24-84567</i>   |  |  |  | 17. INFORMANT & ADDRESS: <i>Geo. F. Casran Pr. Fred, Md.</i>                   |  |   |  |
| 18. MEDICAL CERTIFICATION   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |  |  |   |  |
| 192X IMMEDIATE CAUSE  |  |  |  |  |  |   |  |
| ANTECEDENT CAUSE (S):   |  |  |  |  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |  |  |  |   |  |
| (A) - <i>Malignant - Metastasis in brain</i>  |  |  |  |  |  |   |  |
| DUE TO  |  |  |  |  |  |   |  |
| (B) - <i>Carcinoma</i>  |  |  |  |  |  |   |  |
| DUE TO  |  |  |  |  |  |   |  |
| (C) - <i>Sarcoma of eye (?)</i>   |  |  |  |  |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |  |  |   |  |
| 19A. DATE OF OPERATION:   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State)                                 |  | INJURY OCCUR?   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>April</i> , 19 <i>55</i> , to <i>July 6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>July 6</i> , 19 <i>57</i> , and that death occurred at <i>7 P.</i> M, from the causes and on the date stated above. |  |  |  |  |  |   |  |
| SIGNATURE <i>J. Williams</i>  |  | M. D. <i>St. Thomas</i>  |  | DATE SIGNED <i>7/8/57</i>  |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | DATE THEREOF <i>7/9/57</i>   |  | NAME OF CEMETERY OR CREMATORY <i>Bible Way Church am. Bk. Pr. Fred, Md.</i>    |  | LOCATION (City, town, or county) (State)                          |  |
| DATE REC'D BY LOCAL REGISTRAR <i>7-8-57</i>   |  | REGISTRAR'S SIGNATURE <i>N.W. Ward</i>   |  | 24. FUNERAL DIRECTOR ADDRESS <i>Leroy Berry (Huntingtown, Md.)</i>             |  |   |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

BUREAU V. S.

JUL 12 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6460  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 52

|  |                                |   |  |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <i>Cabot</i>  | MARYLAND                       | STATE <i>Md</i>   | COUNTY <i>Cabot</i>  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  | LENGTH OF STAY (In this place) | CITY (If outside corporate limits write RURAL and give nearest town)  |  |
| <i>x</i> TOWN <i>Sanlingtown</i>   |                                | TOWN <i>Prince Frederick</i> <i>x</i>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                | STREET ADDRESS (If rural, give location)  |  |
| 3. NAME OF DECEASED:   |                                | 4. DATE OF DEATH  |  |
| (First) <i>Raymond</i>   | (Middle) <i>Edwin</i>          | (Last) <i>Durall</i>  | (Month) <i>July</i> (Day) <i>3</i> (Year) <i>1955</i>                        |
| 5. SEX: <i>Male</i>  | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>  | 8. DATE OF BIRTH: <i>Oct 4, 1934</i>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Mary</i>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY: <i>Reserves</i>  | 9. AGE last birthday: <i>20</i> Yrs. IF UNDER 1 YEAR: Months Days Hours Min. |
| 13. FATHER'S NAME: <i>Ashley Durall</i>  |                                | 11. BIRTHPLACE (State or foreign country): <i>VA</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i> (If yes, give war or dates of service)   |                                | 12. CITIZEN OF WHAT COUNTRY: <i>U.S.A</i>   |  |
| 16. SOCIAL SECURITY No.: <i>228-42-4864</i>  |                                | 17. INFORMANT & ADDRESS: <i>Mrs. Raymond E. Durall Prince Frederick Md</i>  |  |
| 18. MEDICAL CERTIFICATION  |                                |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |                                | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 929.8 Immediate cause (a) <i>Drowned</i> DUE TO  |                                |   |  |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO  |                                |   |  |
| stating underlying cause last (c)  |                                |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>Drown while swimming</i>  |                                |   |  |
| 19a. DATE OF OPERATION:  |                                | 19b. MAJOR FINDING OF OPERATION:  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Home</i> )  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>7 3 33 745 M.</i>   |                                | 21c. (City or town) (County) (State) <i>Sanlingtown Cabot Md</i>  |  |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                | 21f. HOW DID INJURY OCCUR? <i>Drowning</i>  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                |   |  |
| SIGNATURE <i>H W Ward</i>  |                                | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>7/14/55</i><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removed</i>   |                                | DATE THEREOF: <i>July 7, 1955</i>   |  |
| NAME OF CEMETERY OR CREMATORY: <i>Healey Cemetery</i>  |                                | LOCATION (City, town, or county) (State): <i>Prince Frederick Md</i>  |  |
| DATE REC'D BY LOCAL REG: <i>July 5, 1955</i>   |                                | 24. FUNERAL DIRECTOR: <i>W. H. Hutchins</i>   |  |
| REGISTRAR'S SIGNATURE: <i>Grace L. Hutchins</i>  |                                | ADDRESS: <i>W. H. Hutchins Annapolis Md</i>   |  |

06468



BUREAU V. S.

11 1955

RECEIVED

6461

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

|  |                            |   |                                    |   |                             |  |  |
|--|----------------------------|---|------------------------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH:   |                            |   |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |                             |  |  |
| COUNTY <u>Calvert</u>  |                            | MARYLAND  |                                    | STATE <u>Maryland</u> COUNTY <u>Calvert</u>   |                             |  |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)   |                            | LENGTH OF STAY (in this place)  |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sunderland</u> |                             |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                            |   |                                    | STREET ADDRESS (If rural give location)   |                             |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                            |   |                                    | 4. DATE (Month) (Day) (Year)  |                             |  |  |
| (Type or Print) <u>Arthur Ennis</u>  |                            |   |                                    | OF DEATH: <u>7 - 6, 19 65</u>   |                             |  |  |
| 5. SEX: <u>M</u>   | 6. COLOR OR RACE: <u>C</u> | 7. SINGLE, (MARRIED) WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH: <u>August 11</u> | 9. AGE last birthday: <u>60</u> yrs.  | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter Laborer</u>  |                            | 10B. KIND OF BUSINESS OR INDUSTRY:  |                                    | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>                                      |                             | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                       |  |
| 13. FATHER'S NAME: <u>Not known</u>  |                            |   |                                    | 14. MOTHER'S MAIDEN NAME: <u>Eliza Johnson</u>  |                             |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                            | 16. SOCIAL SECURITY NO. <u>220-164276</u>   |                                    | 17. INFORMANT & ADDRESS: <u>Edith Ennis Sunderland, Md.</u>                                     |                             |  |  |
| 18. MEDICAL CERTIFICATION  |                            |   |                                    |   |                             | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                            |   |                                    |   |                             |  |  |
| IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>   |                            |   |                                    |   |                             |  |  |
| ANTECEDENT CAUSE (B) DUE TO  |                            |   |                                    |   |                             |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                            |   |                                    |   |                             |  |  |
| (C)  |                            |   |                                    |   |                             |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Died sitting in a chair</u>  |                            |   |                                    |   |                             |  |  |
| 19A. DATE OF OPERATION:  |                            | 19B. MAJOR FINDINGS OF OPERATION  |                                    |   |                             | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                            | 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>Home</u>                        |                                    | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                    |                             |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9:35 6 5 9 PM</u>   |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work |                                    | 21F. HOW DID INJURY OCCUR?  |                             |  |  |
| 22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:30</u> P.M., from the causes and on the date stated above. |                            |   |                                    |   |                             |  |  |
| SIGNATURE <u>Howard Owen</u>   |                            | M. D. <u>Owen</u>   |                                    | DATE SIGNED <u>Wed 7/7/65</u>   |                             |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                            | DATE THEREOF <u>7-9-65</u>  |                                    | NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u>  |                             | LOCATION (City, town, or county) (State) <u>Sunderland Md</u>                    |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7-9-65</u>  |                            | REGISTRAR'S SIGNATURE <u>N.W. Ward</u>  |                                    | 24. FUNERAL DIRECTOR <u>P.E. Sewell Bruce Frederick, Md.</u>                                    |                             | ADDRESS  |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

JUL 12 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 51

|   |                   |  |                     |  |                                  |  |            |
|---|-------------------|--|---------------------|--|----------------------------------|--|------------|
| 1. PLACE OF DEATH:  |                   |  |                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:                               |                                  |  |            |
| COUNTY <u>Calvert</u>   |                   | MARYLAND   |                     | STATE <u>MD</u>  |                                  | COUNTY <u>Calvert</u>  |            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (in this place)   |                     | CITY (If outside corporate limits write RURAL and give nearest town) |                                  |  |            |
| TOWN <u>N. Beach</u>  |                   |  |                     | TOWN <u>N. Beach</u>   |                                  |  |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                   |  |                     | STREET ADDRESS (If rural, give location)                             |                                  |  |            |
| 3. NAME OF DECEASED: (Type or Print)  |                   |  |                     | 4. DATE OF DEATH   |                                  |  |            |
| (First) (Middle) (Last)   |                   |  |                     | (Month) (Day) (Year)   |                                  |  |            |
| <u>Dennis Patrick Fenton Jr.</u>  |                   |  |                     | <u>7 16 1953</u>   |                                  |  |            |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  | 8. DATE OF BIRTH:   | 9. AGE last birthday:  | IF UNDER 1 YEAR IF UNDER 24 HRS. |  |            |
| <u>M</u>  | <u>W</u>          | <u>WIDOWED</u>   | <u>July 20 1891</u> | <u>63</u> yrs.   | Months                           | Days   | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired):  |                   |  |                     | 10b. KIND OF BUSINESS OR INDUSTRY:                                   |                                  | 11. BIRTHPLACE (State or foreign country):   |            |
| <u>Business for</u>   |                   |  |                     | <u>Ja</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |            |
| 13. FATHER'S NAME:  |                   |  |                     | 14. MOTHER'S MAIDEN NAME:  |                                  |  |            |
| <u>Dennis P. Fenton Sr.</u>   |                   |  |                     | <u>Margaret Enright</u>  |                                  |  |            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wnr or dates of service)   |                   |  |                     | 16. SOCIAL SECURITY No.:   |                                  | 17. INFORMANT & ADDRESS:   |            |
| <u>No</u>   |                   |  |                     | <u>Wm D P. Fenton Jr</u>   |                                  |  |            |
| 18. MEDICAL CERTIFICATION   |                   |  |                     |  |                                  |  |            |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |                   |  |                     |  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |            |
| 420.1 Immediate cause (a) DUE TO <u>Coronary disease</u>  |                   |  |                     |  |                                  | <u>1 yr</u>  |            |
| Antecedent cause(s) (b) DUE TO  |                   |  |                     |  |                                  |  |            |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)  |                   |  |                     |  |                                  |  |            |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead in bed at 9 am</u>  |                   |  |                     |  |                                  |  |            |
| 19a. DATE OF OPERATION:   |                   |  |                     | 19b. MAJOR FINDING OF OPERATION:                                     |                                  |  |            |
| <u>7/16/53</u>  |                   |  |                     |  |                                  |  |            |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                   | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc. INJURY)                                 |                     | 21c. (City or town) (County)   |                                  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State) |            |
| <u>9 16 53 9A</u>   |                   | <u>While at work</u>   |                     | <u>Not while at work</u>   |                                  |  |            |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                     | 21f. HOW DID INJURY OCCUR?   |                                  |  |            |
| <u>7 16 53 9A</u>   |                   | <u>While at work</u>   |                     |  |                                  |  |            |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                   |  |                     |  |                                  |  |            |
| SIGNATURE   |                   | CHIEF MEDICAL EXAMINER   |                     | DEPUTY MEDICAL EXAMINER  |                                  | DATE SIGNED  |            |
| <u>H W Ward &amp; Co</u>  |                   | <u>M. D.</u>   |                     | <u>Assistant Medical Exam.</u>                                       |                                  | <u>7/16/53</u>   |            |
| 23. BURIAL, CREMATION, REMOVAL (Specify):   |                   | DATE THEREOF   |                     | NAME OF CEMETERY OR CREMATORY  |                                  | LOCATION (City, town, or county) (State)   |            |
| <u>Removal</u>  |                   | <u>7/19/53</u>   |                     | <u>H. W. Ward</u>  |                                  | <u>Fairfax Va</u>  |            |
| DATE REC'D BY LOCAL REG.  |                   | REGISTRAR'S SIGNATURE  |                     | 24. FUNERAL DIRECTOR   |                                  | ADDRESS  |            |
| <u>7/17/53</u>  |                   | <u>H. W. Ward</u>  |                     | <u>Fairfax Va</u>  |                                  | <u>Fairfax Va</u>  |            |

6462

06470

BUREAU V. 2

JUL 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |   |  |  |   |  |   |   |  |  |
|--|--|---|--|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH   |  |   |  |  |   |  |   |   |  |  |
| Reg. Dist. No. 51  |  |   |  |  |   |  |   |   |  |  |
| Items 13, 14 Film 183 7-8-55 et  |  |   |  |  |   |  |   |   |  |  |
| 1. PLACE OF DEATH:   |  |   |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |   |   |  |  |
| COUNTY <u>Cabaret</u>  |  | MARYLAND                                |  |  | STATE <u>Ind</u>  |  | COUNTY <u>Cabaret</u>   |   |  |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |  | LENGTH OF STAY (in this place)          |  |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  | OR  |   |  |  |
| X TOWN <u>St. Leonard</u>  |  | <u>37 yrs</u>                           |  |  | TOWN <u>St. Leonard</u>   |  | X   |   |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |  |   |  |  | STREET ADDRESS (If rural give location)                               |  |   |   |  |  |
| 13. NAME OF DECEASED: (Type or Print)  |  |   |  |  | 4. DATE OF DEATH:   |  |   |   |  |  |
| (First) <u>Nora</u> (Middle) <u>Virginia</u> (Last) <u>Hardisty</u>  |  |   |  |  | Month <u>July</u> Day <u>2</u> Year <u>1955</u>                       |  |   |   |  |  |
| 5. SEX: <u>F</u>   |  | 6. COLOR OR RACE: <u>W</u>              |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>N</u>   |   | 8. DATE OF BIRTH: <u>Feb. 21, 1876</u>                       |   | 9. AGE last birthday: <u>79</u> yrs. <u>4</u> mos. <u>11</u> days     |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>  |  |   |  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>                        |  | 11. BIRTHPLACE (State or foreign country): <u>Indy - Cabaret Co., Ind</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |
| 13. FATHER'S NAME: <u>Pitcher</u>  |  |   |  |  | 14. MOTHER'S MAIDEN NAME: <u>Bowen</u>                                |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service): <u>No</u>  |  |   |  |  | 16. SOCIAL SECURITY NO. <u>741</u>                                    |  | 17. INFORMANT & ADDRESS: <u>Thomas Hardisty - St. Leonard, Ind</u>        |   |  |  |
| 18. MEDICAL CERTIFICATION  |  |   |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   |  |  |   |  |   |   |  |  |
| IMMEDIATE CAUSE (A) <u>Crohn's Disease</u>   |  |   |  |  |   |  |   |   |  |  |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Generalized Sclerosis</u>   |  |   |  |  |   |  |   |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>  |  |   |  |  |   |  |   |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |  |   |  |  |   |  |   |   |  |  |
| 19A. DATE OF OPERATION: <u>0</u>   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |   | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) |   |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?                                   |   |   |  |  |
| 22. I hereby certify that I attended the deceased from <u>July 2</u> , 19 <u>55</u> , to <u>22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u>22</u> M, from the causes and on the date stated above. |  |   |  |  |   |  |   |   |  |  |
| SIGNATURE <u>R. Williams</u>   |  |   |  | ADDRESS <u>St. Leonard</u>   |   | DATE SIGNED <u>6/2</u>                                       |   |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>July 4, 1955</u>        |  | NAME OF CEMETERY OR CREMATORY <u>Water Memorial</u>  |   | LOCATION (City, town, or county) <u>St. Leonard, Ind</u>     |   | (State)   |  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>7/2/55</u>  |  | REGISTRAR'S SIGNATURE <u>N. H. Ward</u> |  | 24. FUNERAL DIRECTOR <u>A. A. Harkness</u>   |   | ADDRESS <u>St. Leonard, Ind</u>                              |   |   |  |  |

06471

BUREAU V. 31

JUL 6 1955

RECEIVED

6464

## MARYLAND STATE DEPARTMENT OF HEALTH

06472

Items 7,9,11,18,21&22 Film  
G186 9-13-55 amsCERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 52

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <b>Calvert</b>   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Maryland</b> COUNTY <b>Calvert</b>                         |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWN</b>                     |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWN</b> <b>Chesapeake Beach</b> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Chesapeake Beach (bay)</b>                                  |  | STREET ADDRESS (If rural, give location)   |  |
| 3. NAME OF DECEASED (Type or Print)  | (First) <b>GLADYS</b> (Middle) <b>HINES</b> (Last) | 4. DATE OF DEATH   | (Month) <b>July</b> (Day) <b>30</b> (Year) <b>1955</b> |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>                      | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>  | 8. DATE OF BIRTH <b>Oct 7, 1926</b>                    |
| 9. AGE last birthday <b>35</b> yrs.  |  | 10. BIRTHPLACE (State or foreign country) <b>Prince Georges</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Prince Georges</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>Wm. C. Williams</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Rachel Huffman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY No.  |  |
| 17. INFORMANT AND ADDRESS <b>Frances Hines</b>   |  |  |  |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

975X Immediate cause (a) **Drowning**

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

|   |  |   |                |            |
|---|--|---|----------------|------------|
| 21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | PLACE (Home, farm, factory, street, office bldg., etc.)  | (CITY OR TOWN)  | (COUNTY)       | (STATE)    |
| CAUSE OF DEATH  | <b>INJURY Chesapeake Bay</b>   | <b>Chesapeake Beach</b>   | <b>Calvert</b> | <b>Md.</b> |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 30 1955 P m.</b>   | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR? <b>Waded into water- found floating face down</b> |                |            |

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|  |                      |                               |                                  |         |
|--|----------------------|-------------------------------|----------------------------------|---------|
| 23. REMOVAL, CREMATION, BURIAL (Specify) | DATE THEREOF         | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <b>Burial</b>                            | <b>July 31, 1955</b> | <b>Mt. Harmony</b>            | <b>Owings, Calvert, Md.</b>      |         |

|                          |                      |                       |                       |
|--------------------------|----------------------|-----------------------|-----------------------|
| DATE REC'D BY LOCAL REG. | REGISTER'S SIGNATURE | 24. FUNERAL DIRECTOR  | ADDRESS               |
| <b>AUG 1 1955</b>        | <b>Wm. B. Cox</b>    | <b>W. H. Hutchins</b> | <b>Calvert County</b> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



THE MORGUE

BUREAU V. S.

AUG 4 1955

RECEIVED

06474

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6465

CERTIFICATE OF DEATH

Reg. Dist. No. 51

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|  |                            |  |  |   |   |   |  |
|--|----------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH:   |                            |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |   |   |  |
| COUNTY <u>Calvert</u>  |                            | MARYLAND   |  | STATE <u>Ind</u>  |   | COUNTY <u>Calvert</u>   |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)   |                            | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |   |   |  |
| X TOWN <u>Adelina</u>  |                            | <u>Life</u>  |  | <u>Adelina</u> X  |   |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                            |  |  | STREET ADDRESS (If rural give location)                                       |   |   |  |
|  |                            |  |  |   |   |   |  |
| 3. NAME OF DECEASED: (Type or Print)   |                            |  |  | 4. DATE OF DEATH:   |   |   |  |
| (First) (Middle) (Last) <u>Samuel J. Hooper</u>  |                            |  |  | (Month) (Day) (Year) <u>July 10, 1955</u>                                     |   |   |  |
| 5. SEX: <u>M</u>   | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>D</u>   | 8. DATE OF BIRTH: <u>Sept. 9, 1875</u> | 9. AGE last birthday: <u>79</u> yrs.  | IF UNDER 1 YEAR: Months <u>10</u> Days <u>1</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): <u>Cryphonian</u>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Waterman</u>   |  | 11. BIRTHPLACE (State or foreign country): <u>Calvert County Ind.</u>         |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                            |  |
| 13. FATHER'S NAME: <u>Alexander Hooper</u>   |                            |  |  | 14. MOTHER'S MAIDEN NAME: <u>Mary Francis Buckmaster</u>                      |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>No</u>  |                            |  |  | 16. SOCIAL SECURITY NO.: <u>220-16-46789</u>                                  |   | 17. INFORMANT & ADDRESS: <u>John W. Hooper - Adelina, Ind.</u>        |  |
| 18. MEDICAL CERTIFICATION  |                            |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                            |  |  |   |   |   |  |
| 422.1 IMMEDIATE CAUSE  |                            |  |  |   |   |   |  |
| (A) <u>Chy myocarditis</u> DUE TO  |                            |  |  |   |   |   |  |
| ANTECEDENT CAUSE (S)   |                            |  |  |   |   |   |  |
| (B) <u>arteriosclerosis</u> DUE TO   |                            |  |  |   |   |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                            |  |  |   |   |   |  |
| (C)  |                            |  |  |   |   |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                            |  |  |   |   |   |  |
| 19A. DATE OF OPERATION: <u>0</u>   |                            | 19B. MAJOR FINDINGS OF OPERATION   |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                            | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                  |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                            | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |
|  |                            |  |  |   |   |   |  |
| 22. I hereby certify that I attended the deceased from <u>4/1</u> , 19 <u>50</u> to <u>7/10</u> , 19 <u>55</u> , that I last saw the deceased <u>alive on</u> <u>7/6</u> , 19 <u>55</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u> |                            |  |  |   |   |   |  |
| Signature: <u>[Signature]</u> M. D. <u>Dr. Haulingham</u> <u>Ind</u> <u>7/10/55</u> DATE SIGNED  |                            |  |  |   |   |   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                            | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |   | LOCATION (City, town, or county) (State)                              |  |
| <u>Burial</u>  |                            | <u>July 13, 1955</u>   |  | <u>Central Cemetery</u>   |   | <u>Banston - Calvert Co - Ind</u>                                     |  |
| DATE REC'D BY LOCAL REGISTRAR  |                            | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR  |   | ADDRESS   |  |
| <u>7-12-55</u>   |                            | <u>N.W. Ward</u>   |  | <u>C. A. Harkness &amp; Son - Martinsburg, Ind.</u>                           |   |   |  |

FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text follows in several paragraphs]

BUREAU V. A.

JUL 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06475

## 6466 CERTIFICATE OF DEATH

Reg. Dist. No. 51

|  |                                |  |  |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH:   |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |  |
| COUNTY <i>Calvert</i>  | MARYLAND                       | STATE <i>MD</i>  | COUNTY <i>St. Charles</i>                              |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Prince Frederick</i>   | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Upper Marlboro</i>  | 16X-2  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co</i>  |                                | STREET ADDRESS (If rural give location)  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)   |                                | 4. DATE (Month) (Day) (Year)   |  |
| <i>Liggett</i>   |                                | <i>7 9 1955</i>  |  |
| 5. SEX: <i>M</i>   | 6. COLOR OR RACE: <i>W</i>     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH: <i>7/10/1884</i>                     |
| 9. AGE last birthday <i>70</i> yrs.  |                                | IF UNDER 1 YEAR  | IF UNDER 24 HRS.                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Police Officer</i>  |                                | 10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>   | 11. BIRTHPLACE (State or foreign country): <i>NY C</i> |
| 12. CITIZEN OF WHAT COUNTRY?   |                                | 13. FATHER'S NAME: <i>Isaac Lust</i>   |  |
| 14. MOTHER'S MAIDEN NAME: <i>Josling</i>   |                                | 15. INFORMANT & ADDRESS: <i>Wm. Henry Lust Upper Marlboro Md</i>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                                | 17. SOCIAL SECURITY NO.  |  |
| 18. MEDICAL CERTIFICATION  |                                | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                | 6 yrs  |  |
| 420.1 IMMEDIATE CAUSE (A) <i>Coronary disease</i>  |                                |  |  |
| ANTECEDENT CAUSE (S) (B) DUE TO  |                                |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)  |                                |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Was taken with an attack &amp; died</i>                                  |                                |  |  |
| 19A. DATE OF OPERATION: <i>0</i>   |                                | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21B. PLACE (Home, farm, factory, etc.) OF INJURY: <i>Home</i>  |  |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>Upper Marlboro Md</i>  |                                |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                | 21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |                                |  |  |
| 22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at M. from the causes and on the date stated above. |                                |  |  |
| SIGNATURE <i>H W Wand</i>  |                                | DATE SIGNED <i>7/10/55</i>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |                                | DATE THEREOF <i>7-10-55</i>  |  |
| NAME OF CEMETERY OR CREMATORY <i>Washington Heb</i>  |                                | LOCATION (City, town, or county) (State) <i>Washington DC</i>  |  |
| DATE REC'D BY LOCAL REGISTRAR <i>7-9-55</i>  |                                | REGISTRAR'S SIGNATURE <i>H.W. Wand</i>   |  |
| FUNERAL DIRECTOR <i>B. Hanson</i>  |                                | ADDRESS <i>13 Hanson St NE Wash DC</i>   |  |

BUREAU V. S.

JUL 26 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06476

6467

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

|   |                   |  |                     |  |                 |  |       |
|---|-------------------|--|---------------------|--|-----------------|--|-------|
| 1. PLACE OF DEATH:  |                   |  |                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                 |  |       |
| COUNTY <i>Calvert</i>   |                   | MARYLAND   |                     | STATE <i>MD</i>  |                 | COUNTY <i>Calvert</i>                          |       |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |                   | LENGTH OF STAY (in this place)                   |                     | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN  |                 | X  |       |
| X TOWN <i>Prince Frederick</i>  |                   | <i>6 wks</i>                                     |                     | STREET ADDRESS (If rural, give location)   |                 | <i>1</i>                                       |       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co Hospital</i>  |                   |  |                     |  |                 |  |       |
| 3. NAME OF DECEASED: (Type or Print)  |                   |  |                     | 4. DATE (Month) (Day) (Year)   |                 |  |       |
| <i>Ethel Sunderland Plummer</i>   |                   |  |                     | <i>July 14 1955</i>  |                 |  |       |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH:   | 9. AGE last birthday   | IF UNDER 1 YEAR | IF UNDER 24 HRS.                               |       |
| <i>Female</i>   | <i>White</i>      | <i>Widowed</i>                                   | <i>Aug 18, 1880</i> | <i>74</i> yrs.   | Months          | Days   | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   |  |                     | 10B. KIND OF BUSINESS OR INDUSTRY:   |                 | 11. BIRTHPLACE (State or foreign country):     |       |
| <i>Housewife</i>  |                   |  |                     | <i>Domestic</i>  |                 | <i>Calvert Co. Md.</i>                         |       |
| 13. FATHER'S NAME:  |                   |  |                     | 14. MOTHER'S MAIDEN NAME:  |                 |  |       |
| <i>Joseph S. Sunderland</i>   |                   |  |                     | <i>Hannah Fowler</i>   |                 |  |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                   |  |                     | 16. SOCIAL SECURITY NO.  |                 | 17. INFORMANT & ADDRESS:                       |       |
| <i>—</i>  |                   |  |                     | <i>—</i>   |                 | <i>Ms Lee Plummer, Prince Frederick</i>        |       |
| 18. MEDICAL CERTIFICATION   |                   |  |                     |  |                 |  |       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |  |                     |  |                 | INTERVAL BETWEEN ONSET AND DEATH.              |       |
| IMMEDIATE CAUSE   |                   |  |                     |  |                 |  |       |
| (A) <i>Carcinoma of colon</i>   |                   |  |                     |  |                 |  |       |
| ANTECEDENT CAUSE (S)  |                   |  |                     |  |                 |  |       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |                   |  |                     |  |                 |  |       |
| (B)   |                   |  |                     |  |                 |  |       |
| (C)   |                   |  |                     |  |                 |  |       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |  |                     |  |                 |  |       |
| 19A. DATE OF OPERATION:   |                   |  |                     | 19B. MAJOR FINDINGS OF OPERATION   |                 |  |       |
| <i>0</i>  |                   |  |                     |  |                 |  |       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   |  |                     | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                 | 21C. WHERE DID (City or town) (County) (State) |       |
|   |                   |  |                     |  |                 |  |       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   |  |                     | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                 | 21F. HOW DID INJURY OCCUR?                     |       |
|   |                   |  |                     |  |                 |  |       |
| 22. I hereby certify that I attended the deceased from <i>6/8 45155</i> , to <i>7/14</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/4</i> , 19 <i>55</i> , and that death occurred at <i>A. M.</i> from the causes and on the date stated above. |                   |  |                     |  |                 |  |       |
| SIGNATURE <i>W. H. H. H.</i> ADDRESS <i>M. D. Huntingtown</i> DATE SIGNED <i>7/15/55</i>  |                   |  |                     |  |                 |  |       |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   | DATE THEREOF                                     |                     | NAME OF CEMETERY OR CREMATORY  |                 | LOCATION (City, town, or county) (State)       |       |
| <i>Interment</i>  |                   | <i>7/16/55</i>                                   |                     | <i>Friends Cemetery</i>  |                 | <i>Frederick Md.</i>                           |       |
| DATE REC'D BY LOCAL REGISTRAR   |                   | REGISTRAR'S SIGNATURE                            |                     | 24. FUNERAL DIRECTOR   |                 | ADDRESS  |       |
| <i>7/16/55</i>  |                   | <i>Grace L. H. H.</i>                            |                     | <i>H. H. H.</i>  |                 | <i>W. H. H.</i>                                |       |

BUREAU V. 8

JUL 20 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: COUNTY Calvert MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR Port Republic TOWN LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS Berlin 2000 Rodda

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE VA COUNTY Essex CITY (If outside corporate limits, write RURAL and give nearest town) OR Essex TOWN 83X-3 STREET ADDRESS (If rural give location) VA

3. NAME OF DECEASED: (First) (Middle) (Last) Richard Thomas Rodda 4. DATE (Month) (Day) (Year) OF DEATH: 7 5 1955

5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M 8. DATE OF BIRTH: June 18, 1907 9. AGE last birthday 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 10B. KIND OF BUSINESS OR INDUSTRY: Went for July 11. BIRTHPLACE (State or foreign country): West VA 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Rodda 14. MOTHER'S MAIDEN NAME: Bessie Payne VA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) VA 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS: Albert Rodda

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

914.8 IMMEDIATE CAUSE (A) Electrocuted DUE TO

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Was using an elec. sander on a lat

19A. DATE OF OPERATION: 0 19B. MAJOR FINDINGS OF OPERATION 04 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, office street, office bldg., etc.) Home 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? Essex Calvert VA

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 7 5 55 P 21E. INJURY OCCURRED While ☒ Not while ☐ at work ☐ 21F. HOW DID INJURY OCCUR? Was using an elec. sander on a lat

22. I hereby certify that I attended the deceased from 1955, 1955, to 1955, 1955, that I last saw the deceased alive on 7/5/55, and that death occurred at Essex, VA M, from the causes and on the date stated above.

SIGNATURE Dr. Wm. D. Ward M. D. ADDRESS Wm. D. Ward DATE SIGNED 7/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried DATE THEREOF 7/7/55 NAME OF CEMETERY OR CREMATORY Longfellow LOCATION (City, town, or county) (State) Essex VA

DATE REC'D BY LOCAL REGISTRAR 1-5-55 REGISTRAR'S SIGNATURE R. W. Ward 24. FUNERAL DIRECTOR, ADDRESS Wm. D. Ward & Son

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 11 1955

FILED

## CERTIFICATE OF DEATH

Reg. Dist. No.

51

6463

|   |                   |   |                    |  |                 |  |                |
|---|-------------------|---|--------------------|--|-----------------|--|----------------|
| 1. PLACE OF DEATH:  |                   |   |                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:   |                 |  |                |
| COUNTY <u>CALVERT</u>   |                   | MARYLAND  |                    | STATE <u>MO.</u> COUNTY <u>CALVERT</u>   |                 |  |                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                   | LENGTH OF STAY (in this place)                    |                    | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN  |                 |  |                |
| X TOWN <u>PRINCE FREDERICK</u>  |                   | <u>4 DAYS</u>                                     |                    | <u>HUNTINGTOWN, MO</u>   |                 |  |                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CALVERT COUNTY HOSP.</u>   |                   |   |                    | STREET ADDRESS (If rural give location) <u>1</u>   |                 |  |                |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |                   |   |                    | 4. DATE (Month) (Day) (Year) OF DEATH:   |                 |  |                |
| <u>ROSIE</u> <u>WOOD</u>  |                   |   |                    | <u>July 25, 1955</u>   |                 |  |                |
| 5. SEX:   | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH:  | 9. AGE last birthday   | IF UNDER 1 YEAR | IF UNDER 24 HRS.   |                |
| <u>F</u>  | <u>W</u>          | <u>W</u>  | <u>FEB 28 1862</u> | <u>93</u> yrs.   | <u>4</u> Months | <u>27</u> Days   | <u>1</u> Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  |                   |   |                    | 10B. KIND OF BUSINESS OR INDUSTRY:   |                 | 11. BIRTHPLACE (State or foreign country):                   |                |
| <u>Housewife</u>  |                   |   |                    | <u>None</u>  |                 | <u>CALVERT CO. MO.</u>                                       |                |
| 13. FATHER'S NAME:  |                   |   |                    | 14. MOTHER'S MAIDEN NAME:  |                 |  |                |
| <u>GEORGE BOWEN</u>   |                   |   |                    | <u>ANN BUCK</u>  |                 |  |                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):  |                   |   |                    | 16. SOCIAL SECURITY NO.  |                 | 17. INFORMANT & ADDRESS:                                     |                |
| <u>If in</u> <u>no</u>  |                   |   |                    | <u>no</u>  |                 | <u>MRS. W.M. B. BOWEN, HUNTINGTOWN, MO</u>                   |                |
| 18. MEDICAL CERTIFICATION   |                   |   |                    |  |                 | INTERVAL BETWEEN ONSET AND DEATH                             |                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                   |   |                    |  |                 |  |                |
| 450.0 IMMEDIATE CAUSE (A) <u>arteriosclerosis</u>   |                   |   |                    |  |                 |  |                |
| ANTECEDENT CAUSE (S) DUE TO   |                   |   |                    |  |                 |  |                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO  |                   |   |                    |  |                 |  |                |
| (C)   |                   |   |                    |  |                 |  |                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                   |   |                    |  |                 |  |                |
| 19A. DATE OF OPERATION:   |                   |   |                    | 19B. MAJOR FINDINGS OF OPERATION   |                 |  |                |
| <u>0</u>  |                   |   |                    |  |                 |  |                |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                   |   |                    | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                 | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? |                |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                   |   |                    | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                 | 21F. HOW DID INJURY OCCUR?                                   |                |
|   |                   |   |                    |  |                 |  |                |
| 22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>51</u> , to <u>7/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>55</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u> |                   |   |                    |  |                 |  |                |
| SIGNATURE <u>[Signature]</u>  |                   |   |                    | DATE SIGNED <u>7/26/55</u>   |                 |  |                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                   |   |                    | NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)   |                 |  |                |
| <u>Burial</u>   |                   |   |                    | <u>Arboretum Cemetery, Baraboo, Calverton, Md.</u>   |                 |  |                |
| DATE REC'D BY LOCAL REGISTRAR <u>July 29, 1955</u>  |                   |   |                    | 24. FUNERAL DIRECTOR ADDRESS <u>W. H. Hardys</u> <u>9.9. Harkness Rd. - Mount Airy, Md.</u>  |                 |  |                |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED  
JUL 29 1955  
BUREAU V. 8

6470

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. 06479

No. 52

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH:  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  |  |
| COUNTY <u>Calvert</u>   | MARYLAND  | STATE <u>MD</u>   | COUNTY <u>Calvert</u>  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  | LENGTH OF STAY (in this place)  | CITY (If outside corporate limits, write RURAL and give nearest town)   |  |
| <u>Huntington</u>   |   | <u>Huntington</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |   | STREET ADDRESS (If rural, give location)  |  |
|   |   |   |  |
| 3. NAME OF DECEASED:  |   | 4. DATE OF DEATH  |  |
| (First) <u>Carlton</u>  | (Middle) <u>Edward</u>  | (Last) <u>Young</u>   | (Month) <u>7</u> (Day) <u>3</u> (Year) <u>1955</u>                         |
| (Type or Print)   |   |   |  |
| 5. SEX: <u>M</u>  | 6. COLOR OR RACE: <u>W</u>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>  | 8. DATE OF BIRTH: <u>24-13-1944</u>  |
|   |   | 9. AGE last birthday: <u>11</u> yrs.  | 10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY:  | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u>                 |
| 13. FATHER'S NAME: <u>Edward Young</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)  |   | 16. SOCIAL SECURITY No.: <u>—</u>   |  |
| 17. INFORMANT & ADDRESS: <u>Edward Young Huntington</u>   |   |   |  |
| 18. MEDICAL CERTIFICATION   |   |   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Immediate cause (a) <u>Drown</u>  |   |   |  |
| DUE TO  |   |   |  |
| Antecedent cause(s) (b) <u>—</u>  |   |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST (c)   |   |   |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Was swimming &amp; drownd</u>  |   |   |  |
| 19a. DATE OF OPERATION: <u>7-3-55</u>   |   | 19b. MAJOR FINDING OF OPERATION: <u>—</u>   |  |
| 20. AUTOPSY: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>Home</u>                               | 21c. (City or town) <u>Huntington</u> (County) <u>Calvert</u> (State) <u>MD</u>   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-3-55</u> <u>1:30</u> P.M.  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Swimming</u>  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |  |
| SIGNATURE <u>H. W. Anderson</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/14/55</u><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <u>—</u> |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>   | DATE THEREOF: <u>July 6, 1955</u>   | NAME OF CEMETERY OR CREMATORY: <u>Healey Cemetery</u>   | LOCATION (City, town, or county) (State) <u>Prince Frederick</u> <u>MD</u> |
| DATE REC'D BY LOCAL REG. <u>July 5, 1955</u>  | REGISTRAR'S SIGNATURE: <u>Grace L. Hutchins</u>   | 24. FUNERAL DIRECTOR: <u>Wm. H. Hutchins</u> ADDRESS: <u>Durings rd</u>   |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 11 1955

RECEIVED